

co-occurring mental and substance abuse disorders:

a guide for mental health planning + advisory councils



US Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

This guide will help state mental health planning and advisory council members and others assess the programs and services in their state plans for people who have co-occurring mental and substance abuse disorders.

2003

co-occurring mental and substance abuse disorders

Prevalence and Characteristics

One in every five adults, or about 44 million Americans, experiences some type of mental disorder every year. Moreover, five percent of Americans have a severe and persistent mental illness such as schizophrenia and schizoaffective disorders, major depression, and bipolar disorder.¹ According to the U.S. Surgeon General, the United States spent more than \$99 billion for mental, addictive, and dementia disorders in 1996. Indirect costs of all mental illness in 1990, the most recent year for which estimates are available, totaled \$79 billion dollars. These costs include those associated with lost productivity and premature death.

Many individuals with serious mental illnesses have a co-occurring substance abuse disorder. Estimates suggest that up to 7 million adults in this country have a combination of at least one co-occurring mental health and substance-related disorder in any given year.² In comparison to individuals with a primary mental or substance abuse disorder, individuals with co-occurring disorders tend to be more symptomatic, have multiple health and social problems, and require more costly care, including inpatient hospitalization. Many are at increased risk of homelessness and incarceration.

Of an estimated 600,000 people who are homeless on any given day, approximately 25 to 30 percent have a mental illness.³ As many as one half of all people who are homeless and have a serious mental illness also have a substance abuse disorder.⁴ The number of persons with co-occurring mental health and substance abuse disorders, who are also involved with the criminal justice system, is reaching epidemic proportions. About 10 million adults each year enter U.S. jails;⁵ about 700,000 of these individuals have co-occurring disorders.⁶ More than two million youth under the age of 18 are arrested each year, half of whom will have contact with the juvenile



justice system. A high percentage of these youth experience both serious mental health and substance abuse problems.⁷

The presence of co-occurring mental and substance abuse disorders is complex as the illnesses interact with and exacerbate one another. Emerging research suggests that mental disorders often precede substance abuse. It is also the case that alcohol and drug abuse and withdrawal can cause or worsen symptoms of mental illnesses. Substance use also can mask symptoms of mental illness, particularly when alcohol or drugs of abuse are used to “medicate” the mental illness. One disorder may interfere with an individual’s ability to benefit from and participate in treatment for an other disorder. Dysfunctional and maladaptive behaviors can be attributed to either disorder. Individuals with untreated mental disorders are at increased risk for substance abuse. Similarly, individuals who abuse alcohol and other drugs are at increased risk for experiencing mental disorders.

While there is a good deal of variability from person to person and no single set of co-occurring disorders, experts now agree that co-occurring disorders should be seen as the expectation among persons with serious mental illness, not the exception. Therefore, our treatment systems must be designed with their needs in mind.

Unfortunately, for people with co-occurring disorders, the decision to seek professional help can be frustrating and confusing whether they enter the mental health or the substance abuse treatment systems. The mental health system traditionally has tended to exclude persons who also abuse substances, maintaining that the primary work of providers is with mental illness and not with substance abuse. Substance abuse programs often have excluded from treatment persons with mental illness who were taking prescribed medications by requiring individuals entering treatment to demonstrate their motivation by being “clean” of all drugs – including prescribed medications.

Many substance abuse treatment programs have relied heavily on confronting the individual’s denial of a problem at all.

To the contrary, mental health treatment often focuses on shoring the individual's fragile defenses, taking a supportive rather than confrontational approach. Historical differences in culture, philosophy, structure, and funding have contributed to a lack of coordination that has made it difficult for either consumers or providers to move easily across service settings.

These and other differences have contributed to inadequate and costly care and the failure of either system to address the comprehensive needs of consumers. Many of these individuals have long histories of engaging in self-destructive behaviors to cope with the pain of their illnesses. These behaviors often worsen symptoms and cause the individual to lose hope of recovery. People with co-occurring disorders may then become stuck in a cycle of pain, alienation, and self-destructiveness that isolates them from their personal support systems and from treatment systems. Providers themselves may become frustrated, not understanding how to help individuals move away from self-destructive patterns of behavior. Inadequate and costly care has been the result. Individuals and providers both remain stuck in a cycle of hopelessness, with the person with co-occurring disorders feeling like a misfit – “unwelcome, unwanted, and blamed for the complexity of their difficulties.”⁸

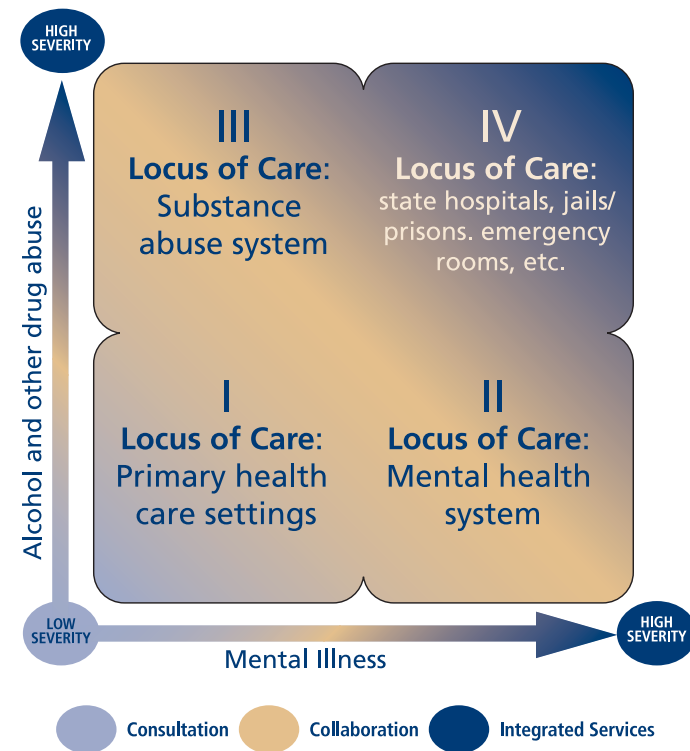
Fortunately, in recent years a growing consensus has emerged asserting the need to do more for this population. Both mental health and substance abuse service providers and systems have a responsibility to understand the disease processes and help clients recover. Research is available that points the way.

Integrated Treatment

Beginning in 1998 with the support of the Substance Abuse and Mental Health Services Administration (SAMHSA), the U.S. Department of Health and Human Services, the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) entered into a

partnership that resulted in the development of a new conceptual framework that presents co-occurring disorders in terms of multiple symptoms and severity instead of diagnosis. The framework provides a visual way of thinking about both the systems of care and the level of service coordination needed to improve consumer outcomes, especially the integrated care necessary for individuals with the most severe mental illnesses and substance use. This conceptual framework combines observations about the current service delivery systems with a vision for the future delivery of integrated services.

Service coordination by Severity



Typically, if they are treated at all, individuals with less severe mental disorders and less severe substance abuse, enter the service system through a primary care setting (Quadrant I). These individuals may present to a primary care doctor, a school-based health clinic or other primary care setting. For persons with mild mental disorders or substance abuse problems, it may be appropriate to manage their psychiatric medications and other treatments in less intensive or specialized settings, such as primary care. When necessary, individuals may be referred to specialized service agencies or providers.

Those individuals with increasingly severe mental disorders accompanied by a lower level of substance abuse are more likely to be seen in a community mental health setting, which provides treatment for the primary mental disorder and also may address the substance abuse problems (Quadrant II). Individuals with a high degree of substance abuse and lower level of mental disorder typically are seen primarily in substance abuse service settings (Quadrant III). While the mental disorders of these individuals may be addressed, the agency's primary expertise remains substance abuse. Referrals to other specialized service settings are common in both Quadrants II and III. These referrals place the burden of connecting the separate treatment systems squarely on the individual and family.

Both the mental health and substance abuse fields generally agree that the most effective treatment for persons with substance abuse and severe mental illnesses – those found in Quadrants II and IV – is integrated treatment, in which services are offered through a single, unified, comprehensive service system.⁹ Integrated treatment matches the intensity of the disorders with a commensurate intensity of treatment interventions. With increasing evidence that any substance abuse by persons with serious mental illness is potentially destabilizing, some treatment professionals and researchers, therefore, are calling for integrated treatment to be available to persons in Quadrant III as well.

An integrated, community-based treatment setting is consumer-centered and provides services through a “no wrong

door” philosophy; that is, no matter how the individual enters care, the services needed to respond effectively to an individual with both severe mental illness and severe substance abuse are available and accessible. Integrated services are often offered through a single-service agency whose staff have been cross-trained and are competent to respond to the unique challenges of co-occurring disorders.

Unfortunately, integrated services are not currently available in most communities. Consequently, many individuals who would benefit from integrated treatment find themselves in hospital emergency rooms, jails and prisons, and other non-health-oriented settings, that may not meet their needs.

There is growing support for the work being conducted by the State Mental Health and Substance Abuse Directors. In 1999, SAMHSA issued a policy statement that enthusiastically supported the conceptual framework for its ability to capture all levels of functional impairment related to mental illness and substance abuse and indicates a need to provide such services on a broader, more systematic basis.

Cultural Competency

A key responsibility of behavioral health care systems is to deliver effective services in an environment that is both welcoming and responsive to individual needs, irrespective of ethnicity, national origin, language, race, religion, age, disability, gender, sexual orientation, or socioeconomic standing. Because the Nation's population is shifting rapidly, this challenge is becoming more complicated.

For example, today, one in three Americans is non-white. By 2050, projections place the population of non-white and/or Latino individuals at 47 percent.¹⁰ According to *Mental Health: Culture, Race and Ethnicity, A Supplement to Mental Health a Report of the Surgeon General* (DHHS, 2001), minorities are less likely than whites to receive needed mental health services and more likely to receive poor quality care. Minorities are over-represented among the Nation's most vulnerable populations (people who are homeless,

incarcerated, or institutionalized), with higher rates of mental disorders and more barriers to care.¹¹

These and other findings suggest it is more important than ever that persons with co-occurring mental and substance abuse disorders be offered services that are culturally-sensitive and tailored to their unique needs.

Promising Practices

Great progress is being made by states and communities to develop and implement effective services for persons with co-occurring disorders. In some states, state mental health agencies and state substance abuse agencies have begun the process of long-term systems change to ensure more effective co-occurring disorder services. Other states have been collaborating, developing, implementing, and evaluating co-occurring services for many years and have valuable lessons to share. Examples of state programs are:

Texas. The State is in its third round of support for pilot projects to serve persons with co-occurring disorders at all levels of severity, with primary funding from the Substance Abuse Prevention and Treatment (SAPT) Block Grant and State mental health general revenue funds. Staff use an integrated service model to deliver services. A total of 14 pilots currently are funded, using a “no wrong door” approach and fully cross-trained staff.

Massachusetts. A Community Action Grant from SAMHSA’s Center for Mental Health Services was used to develop a consensus model for service delivery to persons with co-occurring mental and addictive disorders. A statewide leadership council developed a set of principles for establishing a continuous, integrated system of care. Six regional groups have assumed responsibility for implementing a pilot program in each of their communities based upon these principles.

Missouri. For several years, key leaders in the mental health and substance abuse fields have worked with legislators,

consumers, and providers to redesign the State’s system for delivering services to persons with co-occurring disorders. Regional planning groups are now examining mechanisms to implement a “no wrong door” approach within a managed care framework.

Arizona. Arizona has utilized a consensus-building process to bring key stakeholders together to develop an action plan that outlines the goals and objectives of an ideal system of care for persons with co-occurring disorders across all quadrants. An integrated treatment consensus panel is working to identify gaps in service and make recommendations to bridge them.

Connecticut. Several years ago, the State’s new Department of Mental Health and Addictions Services formed a task force to design a service system that was more centered on the needs of consumers. Significant resources have been committed to cross-train and credential individuals who can demonstrate competence in a set of core skills necessary to serve people with co-occurring disorders.

New York. The State, building successfully upon the long-standing working relationship between the mental health and substance abuse leadership, signed a Memorandum of Understanding that commits resources and details plans to fund pilot projects to serve persons with co-occurring disorders. Co-occurring disorders coordinators address service delivery at the community level.

New Hampshire. Some of the most notable work on co-occurring disorders has been produced by the New Hampshire-Dartmouth Psychiatric Research Center to the benefit of the State’s behavioral healthcare system. Local mental health and substance abuse providers have formed partnerships to serve persons with co-occurring disorders involved with the criminal justice system. Program evaluation suggests there have been fewer arrests, emergency room visits, and hospital admissions among individuals enrolled in the program.

Georgia. The State funds 13 regional units that plan services

for individuals with co-occurring disorders at the regional and community level. Financial incentives encourage regions and communities to save money by reducing use of State hospitals and to reinvest those funds in innovative programs, including co-occurring service programs.

Virginia. Virginia has focused its efforts and resources on both a statewide training needs assessment and cross-training experts to help ensure that mental health and substance abuse provider communities are kept up-to-date on the latest developments in providing services to persons with co-occurring disorders.

Funding Issues

A large gap exists between the services needed by persons with co-occurring disorders and the funds available to pay for those services across the country. Some advocates maintain that funding, rather than client need, has dictated services. Different funds and funding streams are used to support mental health and alcohol and drug abuse services in the States, including State general revenues, Medicaid, local taxes, the Community Mental Health Services (CMHS) Block Grant, and the Substance Abuse Prevention and Treatment (SAPT) Block Grant.

Mental health planning and advisory council members should be aware that in the past there has been some concern and confusion about the use of the CMHS Block Grant and the SAPT Block Grant. As evidenced in the *Promising Practices* section of this document, many states have found creative ways to fund services for persons with co-occurring disorders.

A recent policy statement by the Substance Abuse and Mental Health Services Administration addressed this question of blended funding.¹² According to the statement, funds from the SAPT Block Grant and the CMHS Block Grant may be combined by States to support integrated treatment services for individuals with co-occurring disorders. The 20 percent set-aside for primary prevention services (part of the SAPT Block Grant) also may be used for prevention activities



for those at risk of developing co-occurring substance abuse and mental disorders. According to the same statement, funds from each block grant must be allocated in a manner consistent with the purposes of the particular block grant.

Since states have established different accounting methods to track block grant funds, state mental health planning council members are advised to check with their state mental health and substance abuse authorities on their own state policies and practices. In addition, in some 24 States, the substance abuse authority is a part of the mental health authority, offering a unique opportunity to develop strong program and financial collaborations to serve persons with co-occurring mental and substance abuse disorders.

Role of Planning Councils

State mental health planning and advisory councils can play a pivotal role in helping to plan, implement, monitor, and advocate for effective services for persons with co-occurring mental and substance abuse disorders. Successful services begin by building collaborations at all levels to provide integrated responses to the serious problems faced by this population.

Specifically, state mental health planning council members can -

- Help ensure that the mental health and substance abuse provider communities are aware of the latest research available that documents effective, integrated systems of care. Hold them accountable for delivering the best, state-of-the-science services
- Become educated about service themselves about service programs nationwide that successfully serve persons with co-occurring disorders; study lessons from those with experience; and use that information to work with key providers, funders and advocates from across the state to help ensure that high quality care is available to persons with co-occurring disorders.

It may be unrealistic to expect that many new resources will become available to serve people with co-occurring disorders. States and communities are encouraged to consider funding models that combine different streams of existing funds, and increase capacity in existing service delivery systems.

The Joint NASMHPD and NASADAD Task Force on Co-Occurring Disorders recommends that, in light of funding constraints, state and community co-occurring service providers and advocates can support the best use of available resources by encouraging healthcare service purchasers to:

- *Purchase Effective Services.* Good information is available to help states and communities develop highly effective, integrated services for persons with co-occurring disorders. Those models can be adopted or adapted to suit the needs of individual states. Resources that link to relevant research on this topic are listed in the back of this guide.
- *Purchase Performance.* Clear expectations should be set for program performance, based on available research and on community needs. A program's effectiveness should be judged by the level of change it helps to bring in the lives of consumers with co-occurring substance abuse and mental disorders and their families.
- *Evaluate and Improve.* Measurement of performance outcomes is critical. Programs and the services they provide should be evaluated continually to ensure they are achieving desired results. Rapid feedback to all key stakeholders – including state mental health councils – helps ensure that expectations are met or revised, based on actual performance.

endnotes

- ¹ U.S. Department of Health and Human Services (1999). *Mental Health: A Report of the Surgeon General*. Washington, DC.
- ² U.S. Department of Health and Human Services (1999). *Mental Health: A Report of the Surgeon General*. Washington, DC.
- ³ Center for Mental Health Services and Center for Substance Abuse Treatment (2000). *Insights and Inroads: Project Highlights of the CMHS and CSAT Collaborative Demonstration Program for Homeless Individuals*. Rockville, MD: SAMHSA.
- ⁴ Lezak, A.D., and Edgar, E. (1996). *Preventing Homelessness Among People With Serious Mental Illness: A Guide for States*. Rockville, MD: CMHS, SAMHSA, and U.S. Department of Health and Human Services.
- ⁵ United States Department of Justice Statistics (1997). *Correctional Populations in the United States*. NCJ-163916.
- ⁶ Bureau of Justice Statistics (1998). *Prison and Jail Inmates at Midyear, 1997*. Office of Justice Programs.
- ⁷ Coccozza, J. (Ed.) (1992). *Responding to the Mental Health Needs of Youth in the Juvenile Justice System*. Seattle, WA: The National Coalition for the Mentally Ill in the Criminal Justice System.
- ⁸ Center for Mental Health Services (1998). *Co-Occurring Psychiatric and Substance Disorders in Managed Care Systems: Standards of Care, Practice Guidelines, Workforce Competencies and Training Curricula*. Rockville, MD: CMHS.
- ⁹ Drake, R.E., Mercer-McFadden, C., Mueser, K.T., McHugo, G.J., and Bond, G.R. (1998). *Review of Integrated Mental Health and Substance Abuse Treatment for Patients with Co-Occurring Disorders*. Schizophrenia Bulletin, 24(4): 589-608.
- ¹⁰ U.S. Bureau of the Census (1996). *Resident Population of the United States: Middle Series Projection, 1996-2000 by Sex, Race and Origin, with Median Age*. Washington, DC: Population Division, U.S. Bureau of the Census.
- ¹¹ National Technical Assistance Center for State Mental Health Planning (1999). *Cultural Diversity Series: Meeting the Mental Health Needs of Gay, Lesbian, Bisexual and Transgender Persons*. Alexandria, VA: Author.
- ¹² Substance Abuse and Mental Health Services Administration (1999). *Position statement on use of Substance Abuse Prevention and Treatment Block Grant and Community Mental Health Services Block Grant Funds to treat people with co-occurring disorders*. Rockville, MD: SAMHSA, U. S. Department of Health and Human Services.

references

The following documents form the basis of this brochure. Additional literature sources are cited to build a greater understanding of treatment needs of individuals with co-occurring mental and substance abuse disorders and the role of state mental health planning councils in helping to meet that treatment need.

- U.S. Department of Health and Human Services (1999). *Mental health: A report of the Surgeon General*. Washington, DC: Author.
- U.S. Department of Health and Human Services (2001). *Mental Health: Culture, Race, and Ethnicity-A Supplement to Mental Health: A Report of the Surgeon General*. Washington, DC: Author.
- Center for Mental Health Services (1998). Report of the Center for Mental Health Services managed care initiative: Clinical standards and workforce competencies project. *CMHS Managed Care Initiative: Co-Occurring Mental and Substance Disorders (Dual Diagnosis) Panel*. Rockville, MD: SAMHSA, U.S. Department of Health and Human Services, 1998. [On-line]. Available: www.samhsa.gov
- Center for Substance Abuse Treatment (1994). Assessment and treatment of patients with co-existing mental illness and alcohol and other drug abuse. *Treatment Improvement Protocol (TIP) Series* (Volume 9). Rockville, MD: SAMHSA, U.S. Department of Health and Human Services, 1994. [On-line]. Available: www.samhsa.gov
- Drake, R., Essock, S., Shaner, A., Carey, K., Minkoff, K., Kola, L., Lynde, D., Osher, F., Clark, R., Rickards, L. (2001). Implementing Dual Diagnosis Services for Clients With Severe Mental Illness. *Psychiatric Services*, 52 (4), 469-476.

- Drake, R.E., Mueser, K.T., Clark, R.E. and Wallach, M.A (1996). The course, treatment and outcome of substance disorder in persons with severe mental illness. *American Journal of Orthopsychiatry*, 66 (1):42-51.
- Drake, R.E., et al. (1998). *Reading in dual diagnosis*. Columbia, MD: International Association of Psychosocial Rehabilitation Services.
- Kessler, R.C. (1994). The national comorbidity survey of the United States. *International Review of Psychiatry*, 6:365-76
- Minkoff, K. (1989). An integrated treatment model for dual diagnosis of psychosis and addiction. *Hospital and Community Psychiatry*. 40: 1031-1036.
- National Association of State Mental Health Program Directors Research Institute, Inc. (1999). *Funding sources and expenditures of state mental health agencies: FY 1997*. Alexandria, VA: Author.
- National Association of State Alcohol and Drug Abuse Directors and National Association of State Mental Health Directors (2000). Financing and marketing the new conceptual framework for co-occurring mental health and substance abuse disorders: A blueprint for systems change. *Final Report of the Second National Dialogue of the Joint NASMHPD-NASADAD Task Force on Co-Occurring Disorders*. Alexandria, VA: Authors.
- National Association of State Mental Health Directors and National Association of State Alcohol and Drug Abuse Directors (1999). National dialogue on co-occurring mental health and substance abuse disorders: June 16-17, 1998. *Final Report of the First National Dialogue of the Joint NASMHPD-NASADAD Task Force on Co-Occurring Disorders*. Alexandria, VA: Authors.
- Regier, D., et al. (1990). Co-morbidity of mental disorders with alcohol and other drugs: Results from the epidemiologic catchment area (ECA) study. *Journal of the American Medical Association*, 264 (19), 2511-2518.

resources

US Department of Health and Human Services Substance Abuse and Mental Health Services Administration

Center for Mental Health Services
Center for Substance Abuse Treatment
Center for Substance Abuse Prevention
5600 Fishers Lane
Rockville, MD 20857
Web site: www.samhsa.gov

SAMHSA's National Clearinghouse for Alcohol and Drug Information

Web site: www.health.org

SAMHSA's National Mental Health Information Center

Web site: www.mentalhealth.org

National Association of State Mental Health Program Directors

66 Canal Center Plaza
Suite 302
Alexandria, VA 22314
Phone: (703) 739-9333
Fax: (703) 548-9517
Web site: www.nasmhpd.org

National Association of State Alcohol and Drug Abuse Directors

808 17th St., NW
Suite 410
Washington, DC 20006
Phone: (202) 293-0090
Fax: (202) 293-1250
E-Mail: dcoffice@nasadad.org
Web site: www.nasadad.org

**The National GAINS Center for People with
Co-Occurring Disorders in the Justice System**

Policy Research, Inc.
262 Delaware Ave.
Delmar, NY 12054
Phone: (518) 439-7415
Fax: (518) 439- 7612
E-mail: gains@prainc.com
Web site: www.prainc.com

National Mental Health Association

2001 North Beauregard Street, 12th Floor
Alexandria, VA 22311
Phone: (800) 969-NMHA (6642)
Fax: (703) 684-5968
E-mail: infoctr@nmha.org
Web site: www.nmha.org

National Alliance for the Mentally Ill (NAMI)

Colonial Place Three
2107 Wilson Boulevard, Suite 300
Arlington, VA 22201-3042
Phone: (703) 524-7600
Fax: (703) 524-9094
Web site: www.nami.org

feedback form

SAMHSA and **NAMHPAC** are interested in your feedback. To help make this and future best practices brochures useful to planning and advisory council members, please fill out this section and either cut along the dotted line or photocopy this page and mail it to NAMHPAC at 2001 North Beauregard Street, 12th Floor, Alexandria, VA 22311. Telephone: (703) 838-7522. Fax: (703) 684-5968.

Suggestions for future best practices topics:

- ☐ Evidence-Based Practices
- ☐ Recovery
- ☐ Adult and Juvenile Justice
- ☐ Consumer-Run Programs
- ☐ Other _____

Suggested Changes in Brochure Format or Content:

Substance Abuse and Mental Health Services Administration

The Substance Abuse and Mental Health Services Administration (SAMHSA) within the Department of Health and Human Services is comprised of three Centers that carry out the Agency's mission of improving the quality and availability of prevention, treatment, and rehabilitation services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses.

The Center for Mental Health Services (CMHS) is the agency of SAMHSA that leads Federal efforts to treat mental illnesses by promoting mental health and by preventing the development or worsening of mental illness when possible. Congress created SAMHSA's CMHS to bring new hope to adults who have serious mental illnesses and to children with serious emotional disorders.

The National Association of Mental Health Planning and Advisory Councils

The state mental health planning and advisory councils have joined together to form the National Association of Mental Health Planning and Advisory Councils (NAMHPAC). Federal law requires the establishment of mental health planning councils to review state applications for block grant funding, to serve as advocates for adults with serious mental illnesses and children with serious emotional disturbances, and to monitor and evaluate state mental health planning systems. Although these activities are mandated, many states do not provide funding to support them. In many cases, this lack of funding combined with council members' often short tenures prevent these organizations from making their full impact on service delivery and consumer empowerment. NAMHPAC provides technical assistance to these organizations in the areas of exemplary practices, organizational development, and information sharing. In addition, NAMHPAC provides a national presence on mental health policy issues on behalf of the state planning and advisory councils.

We hope that each planning and advisory council member will closely read this document and use its information to develop the state plan for fiscal year 2003 and beyond. In addition, NAMHPAC will contact members of state councils to encourage them to use these materials, to evaluate how the materials were used, to identify topics for future pamphlets, and to gather suggestions for dissemination of such pamphlets.



**The National Association of Mental Health
Planning and Advisory Councils**

2001 North Beauregard Street, 12th Floor • Alexandria, VA 22311
(703) 838-7522 • (703) 684-5968 – fax